SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1006

SPONSOR: Governmental Oversight and Productivity Committee

SUBJECT: State Employee Health Insurance

DATE: April 1, 2003 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Wilson	GO	Fav/CS
2.			AGG	
3.			AP	
4.			RC	
5.				
6.				

I. Summary:

The bill makes changes to the statutory provisions governing health insurance and prescription drug products, premiums, and coverage provided employees and dependents of State of Florida agencies. It partially implements recommendations made in several legislative and consultant reports.

This bill substantially amends ss. 110.123, 110.161, and 1001.74, Florida Statutes.

II. Present Situation:

Chapter 110, F.S., provides the statutory authority for the implementation of health insurance and prescription drug coverage for officers, employees and their dependents of State of Florida agencies. Employees and retirees may choose between a self-insured indemnity plan, called a preferred provider organization (PPO), or one of several approved health maintenance organizations. Sections 110.123 and 110.12315, F.S., describe the coverage available and specify the minimum complement of benefits each approved provider must offer.

Chapter 216, F.S., contains a procedure for the periodic estimation of revenues and expenses for state employee health insurance. The health insurance estimating conference in that chapter at least annually reviews the income and claims experience of the self-insurance fund in an attempt to forecast the utilization demands and the legislative funding requirements for the succeeding coverage period.[1] The plan is administered by the Division of State Group Insurance in the Department of Management Services. The PPO Plan provides universal access to employees in all Florida counties. Provider contracts with health maintenance organizations are negotiated

[1] The plan is funded on a July through June fiscal years basis with open enrollment in September. The contract cycle, however, is on a calendar year basis.

separately and are available in only thirty-eight counties. Over the past few years, several legislative and consultant reports[2] have documented the precarious state of the finances of the indemnity plan. Among the common findings reported among all of the studies have been:

1. A benefit structure more generous than that provided peer government or large private employers;
2. Co-payment and deductible provisions well below market levels;
3. Significant price subsidies for retirees, dually employed spouses, and families with many children;
4. Employer-pay-all provisions for exempt and managerial personnel;
5. The depletion of indemnity plan reserves as a consequence of a failed management experience with a prior third-party administrator;[3]
6. Cost sharing arrangements based upon a percentage of the subsidized price and not the full cost of the product; and
7. The relative absence of broadly-based wellness or preventive care measures.

These plan attributes co-exist in an employment marketplace also characterized by the following significant changes:

1. A leveling in hiring by state government agencies resulting in the attrition of profit centers of new, younger hires who do not make claims;
2. A progressive increase in retiree-claimants due to the departure into retirement of the "baby-boomer" generation of World War II parents;
3. The greater use of contract vendors in lieu of direct government provision of service delivery;
4. The continued government emphasis of benefit compensation in a larger employment market characterized by salary compensation; and
5. Annual medical cost inflation several times greater than wage growth.

The cumulative effect of these plan and societal changes has been to limit revenue growth and accelerate the claims potential for employee benefits. Unlike a pension plan, health insurance liabilities are "front-loaded," that is, premium amounts are expended for claims payments very soon after their receipt. In contrast, retirement plans[4] are "back-loaded" with payment streams deferred for twenty to thirty years. Moreover, retirement plans all have vesting, or benefit qualification, requirements which deny benefits for participants who fail to meet minimum multi-year service levels. State employee health insurance provides an annual open enrollment period in which individuals can annually change coverage and, to some, extent, engage in

[2] Buck Consultants, *Actuarial Report on Plan and Funding Design Alternatives*, January 29, 2002; Florida Senate, *Improved Choices for and Long-Term Financial Security of State Employee Health Insurance*, Interim Project Report 2003-129, January 2003; Office of Program Policy Analysis and Government Accountability, *Special Review: Options to Redesign State Employee Health Insurance Benefits Presented*, Report No. 01-021, March 2001; Mercer Human Resource Consulting, *State of Florida Employees' Group Health Insurance Program, Report on Program and Funding Design Alternatives*, March 2003.

[3] This experience alone was the subject of a Statewide Grand Jury presentment (OWSP No. 96-292-NFB) that found no criminal wrongdoing but did recommend criminalizing culpable negligence.

[4] A defined benefit, or percent-of-final-pay plan, assures an annuitized pension benefit at a known level. A defined contribution plan makes no such promise but does provide the participant with an equity interest unrealizable in the defined benefit counterpart. Hybrid plans contain attributes of both but are essentially defined benefit plans.

adverse selection, or the expansion of coverage choices at greater employer but lesser employee exposure.

The principal employee workplace benefits are contained in chs. 110 and 121, F.S., in the latter case for retirement. Both chapters contain descriptive and prescriptive provisions: they describe the nature of the benefits and prescribe the precise method of funding. These provisions are then converted into dollar amounts through the estimating conference process and, then, ultimately into payroll amounts and included in the agency legislative budget request. Section 8 of the General Appropriations Act is the location in which salary and benefit provisions are funded. The FY 2004 Governor's Recommended Budget did not contain any provisions for funding of the consensus deficit, noted below. Because of the benefit mandates of ch. 110, F.S., and the inability of an appropriations bill to override substantive law, many of the reported recommendations for change cannot be implemented without amendments to that chapter.

The 2003 Health Insurance Estimating Conference concluded that the state employee health insurance program would end FY 2004 with a net recurring deficit of $135 million. That deficit would grow to an estimated $324 million by the end of FY 2005 without additional revenues, plan changes, or both. The Mercer Report indicated that the most difficult financial period for the indemnity plan would occur at some point between July and December 2003 when plan expenses would exceed revenues.

III. Effect of Proposed Changes:

Section 1. The bill amends s. 110.123, F.S., to make changes to the state employee indemnity group health insurance plan in partial implementation of several legislative and consultant reports, the most recent of which was submitted by Mercer Human Resource Consulting to the Department of Management Services in March 2003.

The changes authorize more than one plan, provide that premium contributions shall be in dollar amounts as opposed to the current percentage of price charged, and permit the department to undertake contract changes through the invitation to negotiate as well as the request for proposal process in ch. 287, F.S.

Sections 2 and 3. The bill amends ss. 110.161 and 1001.74, F.S., to cross reference the continued eligibility of state universities to participate in the pretax benefits program.

Section 4. The bill takes effect July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Subject to the development of specific premium contribution rates, it can be anticipated at this point that there will be two indemnity plans. The "standard" plan will contain high deductible coverage and be more closely aligned with catastrophic insurance. The "plus" plan will more closely resemble the current indemnity plan with increased personal expense. Both plans will have the same prescription drug coverage. Based upon the Mercer report recommendations, there will be premium increases for all participating employees and retirees as well as increases in out-of-pocket expenses, deductibles, and co-payments for prescription drugs. The conversion of the incidence of premium payments from a percentage to a fixed dollar amount will limit the employer's expenses and shift some of the additional burden to the employee.

C. Government Sector Impact:

The following table, taken from the Mercer report, indicates one possible premium scenario. It must be noted, however, that the dollar and coverage amounts are subject to change. These should be considered illustrative of those recommendations but not determined as a result of this bill.

Coverage Tiers and Personal Expense Thresholds Presented in Mercer Report on State Group Health Insurance, 2003

Benefit	Current	Plus	Standard
Deductible			
In-network	$ 150/300	$250/500	$ 1000/2000
Out-of-network	$ 300/600	$ 750/1500	$ 3000/6000
Coinsurance			
In-network	10%	20%	20%
Out-of-network	30%	40%	40%
Out-of-Pocket			
In network	$ 2500/5000	$ 3000/6000	$ 5000/10000
Out-of-network	Cross accum.	Cross accum.	Cross.accum.
Per admission deductible			
In network	$ 150	$ 250	$ 500
Out-of-network	$ 300	$ 500	$ 1000

Physician Office Visit			
In network	$ 10 + 10%	$ 15/25	$ 25/35
Out-of-network	$ 20 + 30%	40%	40%
Emergency Room			
In network	$25+CYD+10%	$ 50	$ 100
Out-of-network	30%	40%	40%
Pharmacy			
Generic retail	$ 7	$ 10	$ 10
Generic mail-order	$ 10.50	$ 20	$ 20
Formulary retail	$ 20	$ 25	$ 25
Formulary mail-order	$ 30	$ 50	$ 50
Non-formulary retail	$ 35	$ 40	$ 40
Non-formulary mail order	$ 52.50	$ 80	$ 80

VI. Technical Deficiencies:

None.

VII. Related Issues:

It is anticipated that the General Appropriations Act will act as the instrument through which future payment and service levels will be executed. The Mercer report also recommends a change from the current two-tier plan (employee/family) to a four-tier plan [employee/employee plus spouse/employee plus child(ren)/ family]. Generally, such an arrangement will increase premiums charged for single employees and family coverage while decreasing it for employee plus spouse and the single parent with child. Central to the Mercer report recommendations is an elimination of the spousal program, that is, the financial forgiveness of all employee insurance premium expense for dually employed spouses. The report also recommends development of a single parent plus child(ren) coverage tier. For the roughly one in eleven covered employees in this status there will be a lessening of premium expense.

In its current form the bill makes no changes to the equalization of premiums charged active and retired employees.

VIII. Amendments:

None.